

Managing HIV Seropositive Prisoners in South Australia: Some Successes and Failures

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The South Australian prison system is relatively small with a total of 966 prisoners accommodated in eight institutions ranging from a maximum security institution at Yatala Labour Prison (264 prisoners) to an open prison farm at Cadell (125 prisoners).

Initial fears in South Australia about HIV/AIDS were expressed as early as 1983 when a union shop steward wrote to the Manager of Yatala Labour Prison on the subject of 'suggested preventive measures to overcome officer exposure to AIDS disease'.

In 1984 information sessions and a video were made available to staff, but it was not until June 1985 that an identified HIV seropositive person was known to be in prison. Prior to this a voluntary blood testing program had been established by the Prison Medical Service with considerable success.

On 19 June 1985, after a series of industrial stoppages occurred, Dr Scott Cameron, Senior Specialist, Communicable Disease Control Unit, South Australian Health Commission, was asked to chair a committee of Health Commission, Correctional Services and union representatives to:

- examine the present practices for handling hepatitis B and AIDS in correctional services institutions; and
- recommend changes to existing practices where necessary.

The recommendations of the Cameron Committee did not include compulsory blood testing but did support voluntary testing. Other recommendations included education of prisoners, offering hepatitis B vaccinations and blood screening, formulation of an occupational health and safety program, special structured drug treatment and rehabilitation programs, provision of single cell accommodation, improved management of sexual predators and control of tattooing practices.

Subsequently, protective clothing was provided to prison officers including gloves for searching and a departmental instruction, 'Procedures and Practices for the Management of Prisoners with Communicable Diseases' (6.6.86), was prepared within a twelve-month period.

However, concern persisted, particularly in institutions such as the old Adelaide Gaol (now closed), where provision for medical facilities and ablutions was grossly inadequate. Again, it was obvious by mid-1987, that industrial trouble was looming.

On 21 May 1987, the then Minister of Health, Dr Cornwall, released a document entitled South Australia's AIDS Strategy which contained a range of policies endorsed by Cabinet. The implementation of this Strategy was the responsibility of the Minister of Health. The document specifically addressed prisoners and HIV/AIDS and was based substantially on the advice of the Crown Solicitor that compulsory testing would be necessary if the Executive Director of the Department of Correctional Services was to execute his responsibilities appropriately for the management and well-being of prisoners.

Prior to the introduction of compulsory testing, pressure had been building for the segregation of prisoners with communicable diseases but, for reasons which will be discussed later, the policy of integration was maintained in South Australia.

The introduction of compulsory testing in August 1987, and the reinforcement of the policy of integration helped ensure that HIV positive prisoners in South Australia stayed in the mainstream prison population. In South Australia as in other States, there was initially strong pressure to segregate on the one hand, and a strong lobby that opposed both segregation and compulsory testing on the other. Those advocating segregation displayed a very normal and basic reaction that often occurs in correctional systems in response to incidents. The traditional reaction to riots or incidents in prisons has been to segregate the prisoners concerned. Similarly, because HIV infection could be linked to homosexual or drug taking behaviours, which were and still are illegal in prisons, the response was predictably to demand segregation. When this perception was linked with the fear created by HIV/AIDS; with what has been characterised as the need to think of people with HIV/AIDS as other than a 'normal' community; and with the strong belief of many that 'medical problems' needed separate treatment, the impetus toward segregation was considerably strengthened. Lloyd (1990, p. 167) suggests that one of the crucial and challenging aspects of AIDS is:

the way it makes visible some of the deeper aspects of our 'normal' thought patterns - our inability to cope with the fear of illness and death, without externalising these things as somehow other to ourselves.

In South Australia because compulsory testing was linked to integration, it became a tool that allowed staff to cope with the situation. Whilst it was recognised that most prisoners were serving short terms in prison and would not be tested, paradoxically perhaps, compulsory testing allowed staff to overcome their concerns.

Emphasising the similarities of HIV transmission patterns with those of other communicable diseases such as hepatitis B was also helpful. This placed the AIDS virus in perspective and allowed the development of policy and procedures relating to communicable diseases in general, rather than for HIV/AIDS alone. The introduction of a hepatitis B immunisation program for prisoners and staff was seen as a positive step, therefore, in preventing communicable disease.

Current Policies in South Australia

The aims of current policies in relation to HIV/AIDS in prisons in South Australia are:

- to limit the transmission of HIV within the prison setting; and
- to manage HIV seropositive prisoners within an integrated prison setting.

The following strategies have been adopted in order to achieve these aims:

Non-custodial sentencing options

In addition to pursuing sufficient accommodation for prisoners to enable single cell accommodation to be provided for the majority of prisoners, it was agreed in the South Australian AIDS strategy that: 'The State Government will encourage the greater use of non-custodial penalties for those offences otherwise likely to attract only a short custodial sentence (South Australia's AIDS Strategy, 1987)'.

Although attempts have been made to reduce short-term sentences, particularly through the use of community service orders, South Australia still has a very high level of short-term prisoners. For example in 1988-89, of the 3892 persons who were released from prison, 2387 (61.3 per cent) served seven days or less in prison. The consequences are that the Department's ability to provide single cell accommodation and special therapeutic units is reduced and the number of HIV seropositive prisoners undetected in the prison is potentially larger.

Compulsory blood testing for all persons in custody for more than seven days

Changes to the regulations made under the Correctional Services Act in 1987 enabled the Permanent Head of the Department:

for the purposes of the assessment of prisoners under section 23 of the Act or of preventing or containing the spread of disease within correctional institutions, [to] direct that all prisoners, prisoners of a particular class or any particular prisoner undergo from time to time such medical examinations or tests as the Permanent Head specifies in the direction. [Regulations to the Correctional Services Act, r. 65(1)]

There have been no difficulties in gaining prisoner compliance with compulsory blood testing.¹

Modified quarantine for seropositive prisoners

This section of the Government's AIDS Strategy was intended to cover medically prescribed conditions and included, for example, the provision of a seweried single cell for accommodation. However, the Department, in its response to the unions stressed that consistent with prescribed medical regimes, prisoners who either demonstrated an assault record in relation to staff or prisoners, or had a history of sexual assault on prisoners could in consultation with the Prisoner Assessment Committee, be placed under a special management plan to protect staff and inmates. In practice this has meant that HIV

¹ Since August 1987 all prisoners serving a sentence of greater than seven days have been tested for HIV and of those imprisoned prior to August 1987, only one prisoner remains untested. Where prisoners have been reluctant to be tested - and this is only an occasional case - the prisoner has been willing to comply after being told that the Regulations state that a prisoner must not hinder or obstruct a medical practitioner in carrying out any such medical examination or test. Because approximately 61 per cent of prisoners in South Australia serve sentences of under seven days, it is impractical to initiate blood testing for these prisoners.

seropositive prisoners have been dealt with according to prison rules, as are other prisoners, and in some cases segregated for a period of time or transferred to another institution.

Retesting of longer term prisoners after three months

All longer term prisoners are retested after three months. Retesting is designed to overcome problems with the seroconversion or window period, although it is recognised that there still may be problems in some instances. It is also proposed, in the near future, to introduce exit testing. Such testing will give an accurate indication, at least for longer term prisoners, of the risks of seroconversion in the South Australian prison system.

Notification procedures - Department of Correctional Services

Currently the Executive Director of the Department of Correctional Services is informed of all cases of HIV seropositive inmates. His delegate, the Assistant Director (Programs), notifies the Manager of the institution, who ensures that staff are informed that the prisoner has a communicable disease. Staff are not told the specific communicable disease. This information would only be released on a 'need to know' basis. A medical regime is supplied by the Medical Officer within an hour of diagnosis, and correctional officers are expected to make themselves familiar with the requirements of that regime.

Notification of third parties

In implementing the South Australian AIDS Strategy, the issue of providing information to the wife of a home detainee, a sexual partner of a prisoner on leave, and in the private visit situation, was raised. This is a potentially difficult area because of concerns for both confidentiality and for the family of prisoners. Following legal advice, it was made clear that there is an obligation to advise third parties in a situation where there is a risk of the disease being communicated by a prisoner during leave. An option that was provided was to decline permission for a prisoner to enter home detention, receive a private visit, or participate in a day leave program if the prisoner objected to a third party being advised or if the third party declined to participate in the particular program when advised.

Education

The provision of education, first for staff and then for prisoners commenced in 1987 when an AIDS educator from the South Australian Health Commission was seconded to the Department of Correctional Services for a six-month period. In 1988, this role was undertaken by a Chief Correctional Officer and then again in 1990 by a staff member reassigned from the Health Commission.

Drug rehabilitation and counselling service

The Cameron Committee recommended the development of structured drug treatment and rehabilitation programs. It suggested that funding could be sought from the Federal Campaign and Strategy against Substance and Drug Abuse. Partly in response to this recommendation, the Department of Correctional Services and the Drug and Alcohol Services Council initiated the Prison Drug Unit which provides a counselling service for prisoners on a state-wide basis. A limited methadone program is also available for prisoners serving very short terms of imprisonment (who were on methadone prior to imprisonment), HIV seropositive prisoners and pregnant prisoners who are drug dependent.

Successes and Failures

In terms of current South Australian policies the major success has been maintaining HIV seropositive prisoners within the general prison population. Part of this success has also been the management of HIV seropositive prisoners with difficult behaviour. A major contributing factor has been the careful assessment and placement process carried out by the Prisoner Assessment Committee which has been facilitated by the relatively small numbers of HIV seropositive prisoners in prison, by the growing experience of correctional management and staff in the management of prisoners with communicable diseases, and by the commitment of the Government to provide modern single cell accommodation for prisoners. Single cell accommodation significantly reduces the risks associated with prisoners sharing cells.

On the other hand it is uncertain whether HIV transmission in the prison environment has been prevented. Anecdotal evidence suggests that needle sharing may constitute a major risk. Until measures such as urinalysis and exit testing are introduced which will provide more accurate data, it is not possible to gauge whether educational campaigns have significantly reduced high-risk behaviour.

On reflecting on our experience in South Australia, there are four major areas I would like to highlight. They are:

- the need to recognise the fear created by HIV/AIDS and to develop ways of overcoming it;
- communicating with staff;
- specific prisoner management problems; and
- concerns about the effectiveness of HIV/AIDS education in prevention.

Fear of HIV/AIDS

There have been several lessons we have learnt in trying to address the fear created by HIV/AIDS. Some of them have their origins in basic counselling strategies, others recognise the importance of involving staff and prisoners, others illustrate the need for staff to link the problems of HIV/AIDS to similar diseases, and others recognise the importance of all members of the prison community receiving the same factual information. Specifically, these lessons have been that:

- it is necessary to start with the individual and recognise the validity of his/her concerns. It is necessary to explore the reasoning behind the fears.
- prisoners should, whenever possible, be involved in the development of educational programs so that programs are credible and reflect the reality of the prison culture.
- recognition should be given to the contribution to prisoner education that some persons with HIV/AIDS can make.

- educational strategies must recognise that the prison is a system where staff and prisoners interact. It is important that both staff and prisoners receive the same factual information so that credibility gaps do not develop.
- the prison community can potentially assist the wider community in HIV prevention. If staff and prisoners are well educated about HIV/AIDS then they have a chance to prevent transmission amongst high-risk groups and can develop a sense of purpose and pride in this role. This role can be continued through community contacts.
- compassion for people with HIV/AIDS must be developed and encouraged and staff and prisoners assisted to recognise that they are potentially at risk.

Many of these lessons are also reflected in the experience of the gay community. Dowsett (1990) for example, in discussing successful education campaigns, points out that the culture of the gay community has been used to reinforce HIV prevention strategies by introducing information into normal community life, invoking a sense of gay pride to link gay men to the practice of safe sex. Similarly, in prisons, it is necessary to use the prison culture and develop a sense of pride in the work that both prisoners and officers can do to prevent HIV.

Communicating with staff

In communicating with prison staff in South Australia, it has been found that linking of hepatitis B and HIV/AIDS has enabled them to cope with, and better understand, the problems associated with communicable diseases and to place the problems engendered by HIV/AIDS into perspective. It has also been important that educational strategies have focused on staff education first and attempted to ensure that both staff and prisoners are given the same information. The latter ensures that staff credibility is enhanced. Similarly, efforts to ensure that staff are immunised against hepatitis B have reassured staff that the Department has genuine concerns about their occupational health and safety. The result has been lower levels of industrial conflict where HIV/AIDS is a major issue.

Specific prisoner management problems

In pursuing a policy of integration in South Australia, several aspects of prisoner behaviour or management have been of concern. It is perhaps unfortunate that the segregation-integration debate has overshadowed the need to look closely at how to manage HIV seropositive prisoners in specific situations such as:

- **Promiscuous or attractive homosexual HIV seropositive prisoners** The admission to prison of young homosexual males who wish to continue their lifestyle and who are seen as at high risk of transmitting the disease within prison, has been of major concern. Currently, it is possible to place such prisoners in smaller institutions or in an environment where their behaviour can be carefully monitored. Fortunately this situation has not occurred frequently, but if the numbers of prisoners who are HIV seropositive increases, then the capacity for such careful placement will diminish.
- **Prisoners who spit, bite etc.** The admission to prison of a prisoner who spits and threatens to bite is obviously of concern to correctional staff. Where such behaviour has occurred the prisoner has been segregated, but not on a long-term basis. It needs to be accepted that just as other prisoners' behaviour will be unacceptable at times, so will the behaviour of HIV seropositive prisoners. However, it needs also to be stressed that such prisoners will be returned to the general prison population and can, like other prisoners, modify their behaviour.
- **Use of syringes as a weapon against officers and prisoners** In South Australia, there have been allegations that prisoners have injected other

prisoners with HIV-infected blood. Obviously, we are aware of events in NSW where, it is alleged that an officer was injected with HIV-infected blood. The fear value of an attack with a syringe, coupled with current penalties for such an offence, are of concern as this may increase the chances of an attack.

- **Harassment of HIV seropositive prisoners** Harassment of HIV seropositive prisoners by other prisoners was initially of considerable concern with groups of prisoners deciding that they wanted HIV seropositive prisoners removed from the prison and making threats against them.

The lessening of these tensions has been evident since 1987, given the firm commitment of the Department of Correctional Services to a policy of integration, the support of managers and senior correctional staff in debating the issues with prisoners, the impact of educational programs, and the growing experience of both staff and prisoners of day-to-day contact with HIV seropositive prisoners.

- **HIV seropositive prisoners and drug use** Although HIV seropositive prisoners who are intravenous drug users can have access to methadone, there are still real fears that such prisoners will continue to use drugs and, potentially, share needles. The need to develop a more comprehensive drug strategy in South Australia is crucial as our options are limited in dealing with such prisoners. Consideration needs to be given to such measures as urinalysis, the use of therapeutic communities and improving the ability to detect drugs being brought into prisons. Penalties imposed on prisoners found to be involved in drug incidents need to be sufficiently severe to act as a deterrent.
- **Release of HIV seropositive prisoners** The release into the community of prisoners who have stated they will not practice safe sex is of concern. Although, legally, the Department of Correctional Services is not obliged to intervene, it raises issues about the capacity of community health services to prevent high-risk behaviour occurring.
- **Specific needs of HIV seropositive prisoners** Most HIV seropositive prisoners have conformed with prison regimes in South Australia but, nonetheless, have expressed concerns about access to special and vegetarian diets, the cost of vitamin tablets on a prisoner's wages, problems in coping with mood swings, and general depression as a result of the disease. Although there is an adequate prison diet, it is understandable that prisoners who want to maintain peak fitness and health are concerned about these issues.

The effectiveness of HIV/AIDS education in the prevention of HIV

Another major issue for South Australia has been whether educational programs will be effective in preventing risk behaviour among prisoners. Gaughwin et al. (1990, p. 63), for instance, whilst finding that prisoners in South Australia had some basic knowledge of HIV infection, also found that:

they and prison officers, think that information about AIDS has not resulted in substantial reduction in some risk behaviours, particularly intravenous drug use. They also think that prisoners need to know more about AIDS to protect themselves adequately. These findings suggest that current information and counselling about AIDS are not meeting prisoners' needs and therefore should be reviewed.

These findings have affected the kind of educational programs offered in South Australian prisons. There has been a move away from using videos and lectures. Attempts

have been made instead to involve prisoners in discussion groups and workshops and to develop education that is relevant to the prison setting. Other methods range from the use of live theatre to the involvement of Aboriginal prisoners in designing posters with HIV prevention messages. However, there are still doubts whether education has reduced risk behaviour, particularly in relation to intravenous drug use.

Conclusion

In examining the management of HIV seropositive prisoners in South Australia, it can be concluded that there has been mixed success in achieving the aims of prevention of the transmission of the virus, and maintaining an integrated prison setting.

It has been possible to successfully integrate HIV seropositive prisoners, and to manage difficult prisoner behaviour. Importantly, there has been careful individual case management of prisoners by the Prisoner Assessment Committee and by institutional staff. This is aided by the fact that the numbers of prisoners who are HIV seropositive remains relatively small.

We have, however only recently started to grapple with the need to move away from looking at HIV/AIDS in isolation and to recognise the need to develop more comprehensive sex and drug strategies to address the main risk behaviours. We also recognise that the segregation-integration debate, together with its attendant industrial problems has diverted us from addressing these issues as quickly as we would have liked. A review of the South Australian AIDS Strategy is currently underway, involving representatives of the Department of Correctional Services, the Drug and Alcohol Services Council and the Prison Medical Service. It is hoped that this will provide an opportunity to reconsider current policies and, particularly, to re-examine our response to institutional sexual acts and the use of intravenous drugs.

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